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ABSTRACT

Family foster care, the mainstay of public child welfare systems, is in critical need of reform. Following a discussion of the efforts of the Annie E. Casey Foundation to assist communities and agencies in confronting this crisis, this paper describes the Family to Family Initiative, a system founded on the view that family foster care reform must be directed to producing a service that is less disruptive to its clients, more community-based and culturally-sensitive, more individualized to the needs of children and families, more available as an alternative to institutional placement, and more family-centered. Grants have been awarded to Alabama, New Mexico, Ohio, Maryland, Pennsylvania, Los Angeles County, and five Georgia counties. The paper describes the current status of the initiative, presents tools developed or used in Family to Family, and contains program description and evaluation information from the Family Match Program in Michigan and the Shared Family Care Program in California. The Shared Family Care Program involves the temporary placement of an entire family in the home of a host family who is trained to mentor and support the biological parents as they develop skills and supports necessary to care for their children and move toward independent living. The Family Match Program also involves mentoring to enhance family functioning, and to preserve and reunite families. (KB)

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FAMILY TO FAMILY: RECONSTRUCTING FOSTER CARE

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and
The States of Alabama, Maryland, New Mexico, Ohio, and Pennsylvania
and
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Los Angeles County, California
Chatham, Emanuel, Fulton, Jenkins, and Screven Counties, Georgia
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The Annie E. Casey Foundation

The Annie E. Casey Foundation was established in 1948 by Jim Casey, a founder of United Parcel Service, and his sister and brothers, who named the Foundation in honor of their mother. The primary mission of the Foundation is to foster public policies, human service reforms and community supports that more effectively meet the needs of today's vulnerable children and families.

The grant making of the Annie E. Casey Foundation is grounded in two fundamental convictions. First, there is no substitute for strong families to ensure that children grow up to be capable adults. Second, the ability of families to raise children well is often inextricably linked to conditions in communities where they live. We believe that community-centered responses can better protect children, support families, and strengthen neighborhoods.

Helping distressed neighborhoods become environments that foster strong, capable families is a complex challenge that will require progress in many areas, including changes in the public systems designed to serve disadvantaged children and their families. In most states, these systems are remote from the communities and families they serve; focus narrowly on individual problems when families in crisis generally have multiple difficulties; tend to intervene only when a problem is so serious that expensive institutionalization is the only response; and hold themselves accountable by the quantity of services offered rather than the effectiveness of the help provided.

Family foster care, the mainstay of all public child welfare systems, is in critical need of reform in each of these areas.

BACKGROUND: THE CURRENT CRISIS IN PUBLIC CHILD WELFARE

The nation's child welfare system continues in crisis. This crisis has four major characteristics:

(1) The numbers of children removed from their families by the child welfare system has continued to grow, from 260,000 children in out-of-home care in the 1980's to more than 500,000 in care by 1995. This growth has been driven by increases in the number of children at-risk of abuse and neglect, as well as by the inability of child welfare systems to respond to the significantly higher level of need.

(2) As these systems become overloaded, they are unable to safely return children to their families or to find permanent homes for them. Children are therefore experiencing much longer stays in temporary settings.

(3) Concurrently, the number of foster families nationally has dropped, so that fewer than 50% of the children needing temporary care are now placed with foster families. As a result of this disparity, child welfare agencies in many urban communities have placed large numbers of children in group care or with relatives who have great difficulty caring for them. An infant coming into care in our largest cities has a good chance of being placed in group care and to be without a permanent family for more than four years.

(4) Finally, children of color are vastly over represented in this group of disadvantaged children.

The duration and severity of the current crisis in child welfare makes this an opportune time for states to challenge themselves to rethink the fundamental role of family foster care and to consider very basic changes.

The Foundation's interest in helping communities and public agencies confront this crisis is built upon the belief that smarter and more effective responses are available to prevent child maltreatment and to respond more effectively when there is abuse or neglect. Often families can be helped to safely care for their children in their own communities and in their own homes--if appropriate support, guidance, and help is provided to them early enough. However, there are emergency situations that require the separation of a child from his or her family. At such times, every effort should be made to have the child live with caring and capable relatives or with another family within the child's own community--rather than in a restrictive, remote, institutional setting. Family foster care should be the next best alternative to a child's own home or to kinship care.

National leaders in family foster care and child welfare have come to realize, however, that **without major restructuring, the family foster care system in the United States is not in a position to meet the needs of children who must be separated from their families**. One indicator of the deterioration of the system has been the steady decline in the pool of available foster families at the same time as the number of children coming into care has been increasing. Further, there has been an alarming increase in the percentage of children in placement who have special and exceptional needs. If the family foster care system is not significantly reconstructed, the combination of these factors may result in more disrupted placements, longer lengths of stay,

fewer successful family reunifications, and more damage done to children by the very system which the state has put in place to protect them.

A RESPONSE TO THE CRISIS: THE FAMILY TO FAMILY INITIATIVE

With the appropriate reforms in policy, in the use of resources, and in programs, family foster care can respond to the challenges of out-of-home placement and be a less expensive and more humane choice for children and youth than are institutions or other group settings. Family foster care reform, in and of itself, can yield important benefits for families and children--although such reform is only one part of a larger agenda designed to address the overall well-being of children and families currently in need of child protective services.

FAMILY TO FAMILY was designed in 1992 in consultation with national experts in child welfare. In keeping with the Annie E. Casey Foundation's guiding principles, the framework for the Initiative is grounded in the belief that reforms in family foster care must be focused on a more family-centered approach that is: (1) tailored to the individual needs of children and their families, (2) rooted in the child's community or neighborhood, (3) sensitive to cultural differences, and (4) able to serve many of the children now placed in group homes and institutions.

The FAMILY TO FAMILY Initiative has been an opportunity for states to reconceptualize, redesign, and reconstruct their foster care system to achieve **the following new system-wide goals**:

1. To develop a network of family foster care that is more neighborhood-based, culturally sensitive, and located primarily in the communities in which the children live.

2. To assure that scarce family foster home resources are provided to all those children (but to only those children) who in fact must be removed from their homes.

3. To reduce reliance on institutional or congregate care (in hospitals, psychiatric centers, correctional facilities, residential treatment programs, and group homes)--by meeting the needs of many more of the children currently in those settings through family foster care.

4. To increase the number and quality of foster families to meet projected needs.

5. To reunify children with their families as soon as that can safely be accomplished, based on the family's and children's needs--not simply the system's time frames.

6. To reduce the lengths of stay of children in out-of-home care.

7. To decrease the overall number of children coming into out-of-home care.

With these goals in mind, the Annie E. Casey Foundations selected and funded three states

(**Alabama, New Mexico,** and **Ohio)** and five Georgia counties in August 1993 and two additional states (**Maryland** and **Pennsylvania**) in February 1994. In addition, **Los Angeles County** was awarded a planning grant in August 1996. States and counties funded through this Initiative were asked to develop family-centered, neighborhood-based family foster care service systems within one or more local areas. Local communities targeted for the Initiative were to be those which have had a history of placing large numbers of children out of their homes. The local sites would then become the first phase of implementation of the newly conceptualized family foster care system throughout the state.

The new system envisioned by FAMILY TO FAMILY is designed to:

- better screen children being considered for removal from home, to determine what services might be provided to safely preserve the family and/or what the needs of the children are;
- be targeted to bring children in congregate or institutional care back to their neighborhoods;
- involve foster families as team members in family reunification efforts;
- become a neighborhood resource for children and families and invest in the capacity of communities from which the foster care population comes.

The Foundation's role has been to assist states and communities with a portion of the costs involved in both planning and implementing innovations in their systems of services for children and families, and to make available technical assistance and consultation throughout the process. The Foundation also provided funds for development and for transitional costs that accelerate system change. The states, however, have been expected to maintain the dollar base of their own investment and sustain the changes they implement when Foundation funding comes to an end. The Foundation is also committed to accumulating and disseminating both lessons from states' experiences and information on the achievement of improved outcomes for children. We will therefore play a major role in seeing that the results of the FAMILY TO FAMILY Initiative are actively communicated to all the states and the Federal government.

The states selected to participate in the planning process are being funded to create major innovations in their family foster care system--to **reconstruct** rather than merely supplement current operations. Such changes are certain to have major effects on the broader systems of services for children, including other services within the mental health, mental retardation /developmental disabilities, education, and juvenile justice systems, as well as the rest of the child welfare system. In most states, the foster care system serves children who are also the responsibility of other program domains. In order for the Initiative to be successful (to ensure, for example, that children are not inadvertently "bumped" from one system into another), representatives from each of these service systems were expected to be involved in planning and implementation at both the state and local level. These systems were expected to commit to the goals of the Initiative, as well as redeploy resources (or priorities in the use of resources) and if necessary alter policies and practices within their own systems.

In summary, the FAMILY TO FAMILY Initiative is founded on a few key value judgments: Reforms in family foster care must be directed to producing a service that is **less disruptive** to the lives of the people it affects, more **community-based** and **culturally-sensitive**, more **individualized** to the needs of the child and family, more available as **an alternative to institutional placement**, and in general more **family-centered**. Further, an enhanced family foster care system also can be consistent with an increased emphasis upon developing alternatives to out-of-home placement for children in the first place. Family foster care can be constructed to serve as a less restrictive setting for children that can speed reunification and assure that out-of-home placements which need to be made are not undertaken until all reasonable efforts to preserve families have been explored. Finally, as a result of the reform, family foster care services should also become a neighborhood resource for children and families, investing in the capacity of communities from which the foster care population comes.

CURRENT STATUS OF FAMILY TO FAMILY

At the outset of the Initiative in 1992, the accepted wisdom among child welfare professionals was that a continuing decline in the numbers of foster families was inevitable; that large, centralized, public agencies could not effectively partner with neighborhoods; that disadvantaged communities could not produce good foster families in any numbers; and that substantial increases in congregate care were inevitable. FAMILY TO FAMILY is now showing that good foster families can be recruited and supported in the communities from which children are coming into placement. Further, dramatic increases in the overall number of foster families are possible, with corresponding decreases in the numbers of children placed in institutions, as well as in the resources allocated to such placements. Perhaps most important, Family to Family is showing that child welfare agencies can effectively partner with disadvantaged communities to provide better care for children who have been abused or neglected. During 1997, child welfare practitioners and leaders--along with neighborhood residents and leaders--are beginning to develop models, tools, and specific examples (all built from experience) that can be passed on to other neighborhoods and agencies interested in such partnerships.

THE TOOLS OF FAMILY TO FAMILY

We believe that FAMILY TO FAMILY is providing to the nation a successful model of a foster care system that is neighborhood-based, family-focused, and culturally appropriate. There is also evidence that an audience exists at the community level, at the state level, and at the federal level for the tools that have been developed to build such a model.

However, all of us involved in FAMILY TO FAMILY quickly became aware that new paradigms, new policies, and new organizational structures were not enough to both make and sustain substantive change in the way society protects children and supports families. New ways of actually doing the work needed to be put in place in the real world. During 1997, therefore, the Foundation and our FAMILY TO FAMILY grantees developed a set of tools which we believe will help others build a neighborhood-based family foster care system. In our minds, such tools are indispensable elements of real change in child welfare.

Tools developed or used in FAMILY TO FAMILY include:

1. Successful strategies to recruit, train, and retain foster families

2. A decision making model for placement in child protection

3. A model to recruit and support relative care givers

4. New information system approaches and analytic tools

5. A self evaluation model

6. Methods to build partnerships between public child welfare agencies and the communities they serve.

7. New approaches to substance abuse treatment in a public child welfare setting

8. A model to enhance worker safety and build resilience among child protection staff

9. Communications planning in a public child protection environment, including how to respond to media crises

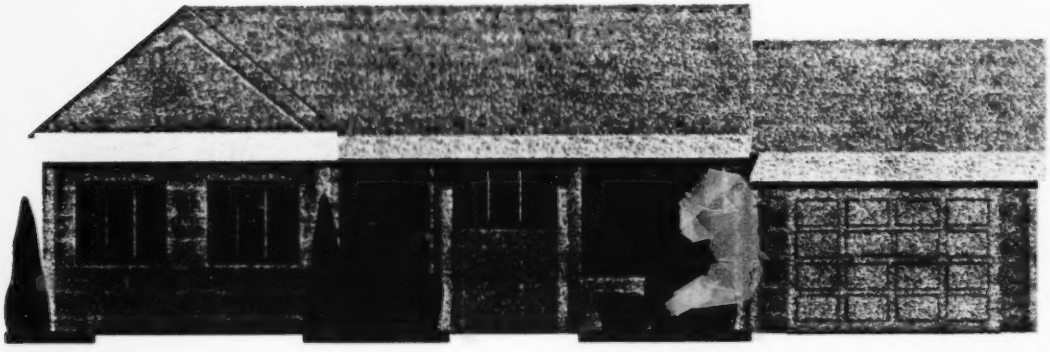
10. A model for partnership between public and private children service agencies

11. Strategies to support families when parents are in prison

12. Proven models which move children home or to other permanent families.

The Annie E. Casey Foundation and its state and local FAMILY TO FAMILY partners look forward to the opportunity to share their learnings with interested communities and agencies.

FAMILY MATCH PROGRAM



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Organization of this Report

This remainder of this report is organized into four sections The next section presents information on FAMILY PRESERVATION AND REUNIFICATION. The following section is a discussion of ENHANCING FAMILY FUNCTIONING. After that discussion is a presentation of the FMP's PROGRAM INSTITUTIONALIZATION. The last section is the SUMMARY OF RECOMMENDATIONS.

FAMILY PRESERVATION AND REUNIFICATION

From March 1994 to November 1995, the Family Match Program has served 61 client families; 39 client families were matched and ten of those client families graduated from the program within nine to 12 months.

During the same period of time, four families (that had been in FMP for more than two months) had their children removed from the home. Of those four families, three were matched with mentor families at the time of the removal; two of these mentor families were licensed foster care families and the clients' children were placed in the mentor's home. One of these two mentor families is in the process of adopting the client's three children.

For more detailed information on client and mentor tracking, please see the End of the Grant Report, 1995 submitted to the Skillman Foundation by the Family Match Program.

ENHANCING FAMILY FUNCTIONING

The primary method used by the FMP to enhance family functioning was the mentoring process. This section contains information on the client and mentor relationships: why the client was referred to FMP, the helpfulness of the mentor, and the accessibility of the clients and mentors to each other. The clients and mentors were also asked to indicate how helpful the client had/has been in helping themselves. As additional indictors of enhanced family functioning, the current

clients and the graduated clients were asked if they would continue contact with the mentor family and resources in their community after they graduate; the mentors also were asked to comment on whether they believed the graduated clients would be able to keep their children in the homes.

Client and Mentor Relationships

The primary reasons given by clients for being referred to the FMP were needing assistance raising their children and not having a support system. All eight of the current clients indicated that their mentor was very helpful with the reasons they were referred to FMP. Six (75 percent) of the clients said the mentor was "very accessible," and two clients (25 percent) indicated "quite accessible."

Current Clients

When the clients were asked to indicate whether their mentor had helped them in 15 specific ways (this list was obtained from FMP documents and staff), all of the clients said "yes" to eight of them. They were:

- Is a positive role model
- Parenting skills training
- Practical skills (i.e., budgeting, shopping)
- Provides some rest time for you away from your children
- Transportation
- Gives effective, trustworthy advice
- Helps you develop your self esteem
- Friendly/Helpful

The other seven specific ways of mentors helping clients were selected by six or seven or the clients.

According to the clients, the most helpful things that Mentors did were transportation (63 percent), talking and spending time with children (63 percent)

and going on family outings (50 percent). When asked how the mentor could be more helpful, the most frequent response was spend more time with the client family. This response was given by four clients; however, one of the clients was currently being seen by the mentor ten hours per week (this is the suggested contact time for the mentors and clients).

Mentors of Current Clients

The eleven mentors were each currently mentoring one or two client families. The length of time with the client families ranged from two weeks to 18 months.

The mentors' responses to accessibility to the clients were slightly less favorable than the clients' responses. More than half (54 percent) of the mentor thought the clients were "Very Accessible"; 27 percent said the clients were "Quite Accessible"; however, two said "Somewhat Accessible".

Graduated Client

This client was referred to the FMP for support services. The client indicated that the mentor was very helpful and accessible. The client said the mentor provided all the 15 specific supports identified by the FMP program.

According to this graduated client, the mentor was most helpful to her with transportation, talking and spending time with the children, talking a lot about religion and other things, and cooking.

Mentors of Graduated Clients

The mentors of graduated clients had mentored from one to four families; the length of time mentoring any family ranged from three to 12 months.

While their clients were in FMP, four of the mentors had telephone contact at least once a week; the other client did not have a telephone. All of the mentors had face-to-face contact; three saw their clients at least weekly and two saw their clients at least once every two weeks. However, since the client graduated, the telephone contact had ranged from at least once a week to not at all. The personal contact had been varied too; one mentor indicated at least once a week, one indicated once a month and three mentors said less than once a month.

Recommendation

Continue to provide opportunities for family outings and continue to encourage the mentors to have frequent face-to-face contact with the client family. Clients most often referred to the time spent with their mentors as the most helpful aspect of the mentoring process.

Clients' Self-Help

Current Clients

When clients were asked to name one or two things they were doing now that they were not doing before they came to the FMP, they most often said getting a job (63 percent), going to school (25 percent) and being patient with their children (25 percent).

Mentors of Current Clients

The mentors' judgments as to how helpful their clients had been in helping themselves make a positive change were varied. Two mentors (18 percent) said "very helpful," six mentors (54 percent) said "quite helpful" and three mentors indicated "somewhat helpful."

The most frequently mentioned helpful characteristics of clients that mentors stated were:

- Client has a willing attitude (90%)

- Client is open to discuss their situation (63%)
- Client is persistent (54%)
- Client is independent (27%)
- Client plans ahead (18%)

The most frequently cited ways in which clients could be more helpful to themselves were:

- Feel better about her/himself (63%)
- Be willing to try new ideas (54%)
- Plan ahead (45%)
- Be more honest about feelings (27%)

Graduated Client

Among the things that she did to help herself was go to school and get the family closer. (The other comments she made would immediately identify the client.)

Mentors of Graduated Clients

When these mentors were asked to indicate how helpful their clients were in helping themselves to make positive changes, one mentor said "Very Helpful", two mentors responded "Quite Helpful", one responded "Somewhat Helpful" and the remaining mentor said "Not Too Helpful".

When mentors were asked to indicate the things that their clients did that were most helpful to themselves, the predominate response was that the client had a willing attitude (100 percent). The second most frequent responses (40 percent each) were that the client was open to discuss their situation, the client was independent, and the client was persistent.

Mentors indicated that their clients could have been be more helpful to themselves by feeling better about themselves (60 percent), planning ahead (60 percent), being more honest about their feelings(40%) and stop doubting people and trusting more (40 percent).

Recommendation

Excellent topics for client group meetings as well as topics for mentors to emphasize with their clients are being honest about their feelings, feeling better about themselves, trying new ideas, being willing to trust others and planning ahead. Mentors think that clients, in general, could be more helpful to themselves.

Future Aspirations

Clients

The current clients and the graduated client were asked if they would continue contact with the mentor family and/or continue to use resources in their community after they graduate. (The FMP staff believe that the client family chances of maintaining an intact family are increased if these two factors occur.) The clients were also asked if they would like to become a mentor. The current clients responses were rated on the scale of 1 to 5 where "Yes, Definitely" was 5 and "No, Definitely Not" was 1. The mean responses of the current clients were:

Future Aspirations	Mean of Currents Clients
Contact With Mentor Family	4.6
Contact With Resources In Your Community	4.6
Would Like To Become A Mentor	3.0

The graduated client said she has continued to see the mentor family and use resources in her community. She also said she would probably like to become a mentor in order to help other people.

The five mentors of graduated clients were asked whether they believed their former clients would be able to keep their children in the home. Three said "Yes" and two said "No". Their reasons are below.

Yes

- Because she married the children's father and has a job. And she's a good parent.
- Because I've seen more growth in the client.
- She is better at budgeting and her patience with her youngest child is improving.

No

- Because he didn't plan for the future. He lived day to day, not taking care of a lot of things.
- She's 19 years old, has 3 kids and has limited financial resources. Besides, she started using cocaine and her boyfriend is abusive.

Recommendations

Follow-up with clients who express an interest in becoming a mentor. Perhaps they could be paired with a current mentor and share a client family.

Invite graduated clients to some of the FMP events; this would provide another positive support mechanism in their lives. The graduated clients could also be role models for the current clients.

PROGRAM INSTITUTIONALIZATION

Program Institutionalization is defined in the FMP goals as developing a successful pilot program which may be funded on an ongoing basis at Spectrum by DSS and that can be replicated by other agencies. FMP has applied for funding from DSS. The application has been reviewed and FMP is awaiting a decision in January 1996.

The success of the program is viewed through the eyes of the clients and mentors. This first part of this section is devoted to reporting on the clients' and mentors' satisfaction with the FMP. The second part of this section is a presentation of the FMP staffs' reflections over what they have learned during the two years of this program that would be beneficial to future replicators of the project.

Clients' and Mentors' satisfaction with the FMP

FMP Services To Clients

The current clients were asked to rate three areas of service of the FMP. The Family Worker, the Group Meetings and the Family Activities were rated on a scale of "Excellent" (4), "Good" (3), "Fair" (2) and "Poor"(1). The mean ratings were:

FMP Services:	Mean of Current Clients:
Family Worker	3.6
Group Meetings	3.6
Family Activities	3.9

When asked to name three ways that the FMP is/was most helpful, the current clients and the graduated client most often mentioned bus tickets (n=6), clothes (n=3) and food (n=3). The most frequent response to the question of what could the FMP do to be more helpful was to have more family outings (n=5).

FMP Services to Mentors

The mentors of current and graduated clients were asked to rate three areas of service of the FMP. The Family Resource Guide, Training/Support Sessions and the Family Worker were rated on a scale of "Very Satisfied" (5), "Quite Satisfied" (4), "Somewhat Satisfied" (3), "Not Too Satisfied" (2) and "Not At All Satisfied" (1). The mean ratings were:

FMP Services:	Mean of Mentors of Current Clients:	Mean of Mentors of Graduated Client:
Family Resource Guide	3.9	4.0
Training/Support Sessions	4.2	3.6
Family Worker	4.5	4.6

Ten of the eleven mentors of current clients said they would definitely continue as a mentor when their current client graduates. The other mentor said "maybe." The reasons for wanting to continue as a mentor were:

- Because I feel I have a lot to offer someone who needs help. I have a lot to teach them.
- It is a very good program.
- This fulfills my need to be a mother--when I can, and if I can.
- I enjoy caring for others.
- I feel client needs that input and support mentors give.
- It's a challenge. I enjoy working with the children and I want to help.
- Because this is a field I really enjoy working in. I enjoy doing what I'm doing.
- I enjoy being a mentor and working/doing things together with families.

Only one mentor of graduated clients was not currently mentoring and was not considering mentoring again because of the time constraints of working two jobs.

Overall Program Satisfaction

The means for overall program satisfaction for all clients and mentors ranged from 5 to 4.6 on a scale of 5 to 1 where 5 was "Very Satisfied" and 1 was "Not At All Satisfied." Clients and mentors were asked to name two things that stood out in their minds about how the Family Match Program has/had been helpful; some representative comments are (all of the verbatim comments are attached to the data summaries in Appendices E, F, and G):

Clients

- They didn't take my babies.
- Helped me raise my children.
- Household items.
- Clothes.
- Very caring staff.

Mentors

- The program has helped the relationship between mother and child.
- I've been able to invest in the next generation.
- It is helpful trying to reach some of the mothers and to keep the family together.
- It helped my client turn on utilities and with basic necessities. It gave her encouragement and coping techniques.
- It helped me understand underprivileged families.

Suggestions for Program Improvements

The complete list of program improvements is a part of each data summary. The most salient suggestions given were:

- Give clients a certificate at end of the program.
- More family outings.
- More groups to establish a bond (more than bi-weekly).
- The program should be longer than one year, especially when the client still needs assistance.
- Make sure that the monthly meetings where children, parents and mentors come together are meaningful and structured so that the participants learn something.
- When a crisis arises at the end of their one-year term, the situation should be evaluated as to whether they should remain in the program longer.
- Matching should occur sooner; this mentor is still waiting, even though she knows that some mentors have more than one client.

Recommendation

In order to maintain a quality program that is responsive to the needs of the participants, FMP staff should consider the program improvement suggestions given by clients and mentors. Overall, clients and mentors were quite satisfied with the services and staff of the FMP.

"Learnings" Of FMP Staff

The FMP staff (administrator, intake worker and two family workers) were interviewed as a group. Care was taken that each person was given an opportunity to respond to each area of learning. FMP staff were also given the option of faxing FERA additional responses during the following week; no fax responses were received. The following question was asked:

> As you reflect back over the past two years, what "**learnings**" come to mind that are important for the success of the Family Match Program?

You can also think of "**learnings**" as those things you would share with individuals operating similar programs or replicating the Family Match Program. Please list your "**learnings**" in the following areas:

Program Staff

The four staff were in agreement on the essential characteristics needed for a FMP staff person:

- Outreach type of person; FMP is not a desk job or 9-to-5 job.
- Works independently, a self-starter.
- Able to go and find resources for clients.
- Interest in working in the inner city.
- Participator in activities.
- Day-care experience or former teacher would be helpful.
- Good human relations skills.
- Good writing skills.

Mentors

Unanimously the staff said, "Do not hire mentors that are in it for the money!" Their other comments were:

- A better screening process is needed to screen out the individuals who primarily want to work for the money and the individuals that have few or no contacts with the clients.
- Look for the mentors who are sincere and have a true concern for the client.
- Consider a probationary period for mentors; this way it is easier to terminate mentors who aren't working out.
- Provide training for the mentors to enable them to teach the clients (e.g., parent skills, budgeting methods) and to work with clients who have special needs (e.g., developmentally delayed clients, recovering substance abusers).

- Do not match mentors with more than two clients. Some mentors can only handle one client. Those mentors who can be assigned two clients are generally individuals not working outside of the home and/or who work in the mental health field.

- Constantly monitor the mentors in order to maintain a quality program.

Clients

Three primary comments were made concerning clients:

- Self-referral clients are difficult to manage. They don't have the pressure of the Department of Social Services and the courts mandating them to attend or have their children removed from the home. Their motivation for joining the program is most often to get a mentor for transportation services and a baby-sitter.

- The program needs the trained staff to deal with clients who are actively using drugs.

- Programs should consider working with clients in shelters; perhaps the clients' length of stay in the shelter would be shortened by mentors working with the clients.

Program Activities

The staff made general comments about the clients' participation in the FMP activities:

- Attendance in activities is seasonal; clients are less inclined to attend meetings when it is cold or rainy.

- Clients are more numerous at meetings when the meetings are fun or "goodies" (e.g., food, clothing) are given out.

- Transportation for clients is important to enable them to attend meetings, but it is also important for clients to become independent and provide their own transportation.

- It is important to link clients with other services in the community; FMP cannot provide comprehensive services to the clients.

- If clients are court-ordered to attend other trainings (e.g., parenting workshops) in the community, this would be an incentive for clients to regularly attend.

Administrative Tasks

The following five "learnings" were expressed by the FMP staff:

- The less paperwork, the better for staff and mentors.
- Collect only the data needed for accountability and program management. Eliminate "nice to know" data.
- Provide training for mentors on how to write the monthly reports. Some mentors write very cryptic notes and others write volumes each month.
- A program manual is essential and should be developed for new programs as soon as possible. The manual should include all job descriptions, a description of the program including the mission statement, all programmatic (e.g., mentor and staff narrative forms) and personnel (e.g., vacation and sick forms) forms with instructions and all other policies and procedures for the program.
- Be flexible and be willing to change procedures or ways of operating (e.g., the minimum requirements for clients and mentors were revised several times; the treatment plan guidelines were modified to include client treatment goals as well as standard program goals).

Linkages with Other Agencies and Individuals

FMP staff emphasized the importance of linking with other community services in order to provide a wide spectrum of services to the client families.

- Refer clients to other agencies for services instead of duplicating services. Collaborations with other agencies are essential for most funding sources.
- The primary community connections should be with parenting agencies, community mental health agencies, schools, recreational facilities, churches, corporations to sponsor events for clients, and the Department of Social Services.

At the end of the group interview, each staff person was asked to describe their "high" and "low" points with the FMP.

High points:

- Seeing a client graduate from FMP and the family is intact.
- Working with sincere mentors who care about the clients from the bottom of their hearts and seeing the mentors' gratification when the client family does well.
- Seeing how the program has grown in the last two years; it has worked and succeeded despite the nay-sayers who did not believe the program would work.

Low points:

- Seeing children come into foster care.
- Disappointing to see mentors who want to be in the program just for the money
- Disappointing that some people in the field of social work don't see the move of the future of working with mentors.
- Seeing workers of other programs trying to dump clients on FMP that are not eligible for our program (e.g., actively using abusive substances). Staff of other programs don't want to be bothered with some of their clients and they aren't aware of the limitations of what the FMP can do with clients.

Recommendations

The FMP staff's "learnings" provide excellent recommendations for their own program to continue or institute and for future replicators. The FMP staff were very thoughtful in reflecting over the "leanings of the past two years.

SUMMARY OF RECOMMENDATIONS

The following is a summary of the six recommendations made in the body of the report.

Family Preservation and Reunification

- **Continue to provide opportunities for family outings and continue to encourage the mentors to have frequent face-to-face contact with the client family.** Clients most often referred to the time spent with their mentors as the most helpful aspect of the mentoring process.

Enhancing Family Functioning

- **Excellent topics for client group meetings as well as topics for mentors to emphasize with their clients are being honest about their feelings, feeling better about themselves, trying new ideas, being willing to trust others and planning ahead.** Mentors think that clients, in general, could be more helpful to themselves.

- **In order to maintain a quality program that is responsive to the needs of the participants, FMP staff should consider the program improvement suggestions given by clients and mentors.** Overall, clients and mentors were quite satisfied with the services and staff of the FMP.

- **Follow-up with clients who express an interest in becoming a mentor. Perhaps they could be paired with a current mentor and share a client family.**

- **Invite graduated clients to some of the FMP events; this would provide another positive support mechanism in their lives. The graduated clients could also be role models for the current clients.**

Program Institutionalization

- **The FMP staff's "learnings" provide excellent recommendations for their own program to continue or institute and for future replicators.** The FMP staff were very thoughtful in reflecting over the "learnings of the past two years.

Abandoned Infants Assistance
RESOURCE CENTER
1950 Addison, Suite 104
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AIA FACTSHEET

Number 4, April 1997

SHARED FAMILY CARE

***Shared Family Care* (SFC) refers to a situation in which an entire family is temporarily placed in the home of a host family who is trained to mentor and support the biological parents as they develop skills and supports necessary to care for their child(ren) and move toward independent living.**

- SFC is a **reparenting program** in which adults learn parenting and living skills necessary to become adequate parents and maintain a household while dealing with their own personal issues and establishing positive connections with community resources.

- SFC offers an **alternative to traditional family preservation and out-of-home services**. By simultaneously ensuring a child(ren)'s safety and preserving a family's ability to live together, SFC prevents unnecessary out-of-home placement.

- SFC can be used for **prevention**—making it unnecessary to separate a parent(s) from her or his child; for **reunification**—providing a safe environment in which to reunite a family that has been separated; or to help parents make the decision to terminate their parental rights.

FREQUENTLY ASKED QUESTIONS ABOUT SHARED FAMILY CARE

Question: How does SFC differ from regular foster care?
Answer: In SFC, the entire family (i.e., at least one parent with at least one child) is placed together in another family's (the "host" or "mentor") home. Although the host family serves as an advocate, resource and mentor in parenting and daily living skills, the biological parent(s) maintains primary responsibility for the care of her/his child. In regular foster care, children may learn a different way of life; in SFC, children and their parents learn to live together as a family.

Question: Who would be willing to take another family with multiple issues into their home?
Answer: Shared family care mentors have varied backgrounds, family structures and life experiences. Some have been regular foster parents who recognize the importance of keeping families together and helping parents learn how to care for their children. Others have an interest in working with parents who may, for instance, share some of their life experiences (e.g., recovery from alcohol or other drugs). The most important qualifications for mentors are an interest in and ability to work with adults; an understanding of child care, safety and development; and a genuine desire to help families by participating in an innovative, non-traditional program. Like recruitment for traditional foster parents, the most effective strategy for recruiting SFC mentors is word of mouth.

Question: Do mentor homes have to be licensed? If so, how?
Answer: Because SFC serves intact families in private homes, state licensure should not be required. Mentor homes, however, must meet certain criteria regarding space, sleeping areas, and health and safety regulations. A child foster care license provides certain protections for both families (mentor and client) and enables a child to remain in the mentor's home with the same care provider if the parent relinquishes her/his parental rights or is otherwise separated from the child. This alternative, however, typically requires a waiver from the state licensing agency to allow an adult related to the child to reside in the same home.

Question: How does the cost of shared family care compare with the cost of traditional foster care or family preservation?
Answer: The monthly cost of SFC typically is higher than basic family foster care, comparable to treatment foster care, and less than institutional care or intensive family preservation (see chart below). However, because SFC placements

ESTIMATED COST OF CARING FOR ONE CHILD/FAMILY*			
Category of Cost	**Average Monthly Maintenance Cost**	**Median Service Duration**	**Average Total Maintenance Cost**
Conventional Supervision	$233	6 months	$1,400
Intensive Family Preservation	$2,800	1.5 months	$4,200
Basic Family Foster Care	$362	14 months	$5,068
Shared Family Care	**$1,575**	**5 months**	**$7,875**
Treatment Foster Care	$933	14 months	$13,062
Transitional Housing Program	$3,000	6 months	$18,000
Residential Drug Treatment	$3,242	6 months	$19,454
Institutional Care	$3,600	13 months	$46,800

*Note: The above data is based on National averages with the following exceptions: The median service duration for basic family, treatment, and institutional foster care are based on California statewide averages, and the data for Shared Family Care is based on an average of two programs: *Whole Family Placement* in St. Paul, MN, and *A New Life Program* in Philadelphia, PA.

typically are shorter than foster care and often more effective than other strategies at preventing subsequent abuse or neglect, SFC appears to be, at a minimum, cost neutral. Factoring in the efficiency of placing more than one child in the same home with their parents, thereby eliminating the need for other shelter arrangements, SFC may result in fiscal savings if it achieves permanency for children at an earlier point.

***Question:** What funds are available to pay for shared family care?*

Answer: State and Federal Family Preservation programs are the most viable source of funds for placement, case management and mentor compensation. Title IV-E (Foster Care and Adoption) funds can finance the placement of *teen* parents in mentor homes. TANF also should be available to support client families in shared family care and finance some of the supportive services. State and local child welfare, substance abuse and homeless programs may also be available to finance certain parts of SFC. Private resources can support planning, start-up and evaluation, and they may help fill in other funding gaps (e.g., respite, training and aftercare).

***Question:** Has anyone successfully implemented shared family care?*

Answer: At least three (3) programs in the U.S. have been using this model for several years. *A New Life* Program, at Crime Prevention Associates in Philadelphia, PA, uses SFC as part of an intensive drug treatment program for women with infants. Minnesota Human Service Associates, a treatment foster care agency in St. Paul, MN, provides SFC to a wide variety of families through their *Whole Family Placement Program.* Children's Home and Aid Society of Illinois, in Chicago, provides SFC through their *Adolescent Mothers Resource Homes* program for teen parents who are in the foster care system. (See contacts on page 4.) Additionally, pilot programs are developing via public and private agencies in California, Colorado and Wisconsin.

***Question:** Is there any outcome information from any of these programs?*

Answer: In the first two years of implementation, 23/46 (50%) of the families in Minnesota HSA's *Whole Family Placement Program* moved as a family to independent housing with no Child Protective Service (CPS) involvement. Eight of the parents (17%) left their children in foster care, and 5 of those children were subsequently adopted. The remaining families were still in placement at the time of the report. Note that of the 23 families who moved onto independent living, none of them had subsequent involvement with CPS within six months after placement termination. In contrast, approximately 15% of children who are reunified with their families after a regular foster care placement re-enter care within six months.

***Question:** What families are most likely to benefit from a shared family care placement?*

Answer: SFC is not appropriate for all families and cannot be mandated for anyone. On the other hand, the model can work for families of all kinds with a wide variety of issues and needs. Eligible families should have at least one parent who: demonstrates desire to care for her/his child(ren) and "readiness" to work on an individualized service plan; requires some supportive service in order to learn adequate parenting and living skills; and is marginally housed or willing and able to temporarily leave her/his current living situation. SFC is not recommended for families who are actively abusing alcohol or other drugs, actively violent or involved in illegal activities, or severely mentally ill without appropriate treatment. The following stories illustrate the experiences of three families who benefited from SFC—two in Minnesota HSA's *Whole Family Placement Program*, and one in Crime Prevention Association's *A New Life Program*.

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CASES IN POINT

Rosie, a 27 year old woman with an IQ of 74 and a third grade reading level, loved her children and would do anything to keep them. When Rosie's 5 year old son, Josh, was sexually abused by her boyfriend, she didn't know what to do or how to help him because she too had been sexually abused as a child. When CPS learned about Josh's abuse, he was removed from Rosie's home and placed with her sister. Rosie subsequently had a baby girl who also was placed with her sister. When her daughter was 3 months old, CPS was moving to terminate Rosie's parental rights (planning to leave her son with her sister and place her daughter up for adoption) when they decided to give her one last chance—shared family care. After a careful screening process, Rosie moved with her two children into Cissy's home.

While in care, Josh received professional therapy and Cissy helped Rosie become more consistent in her parenting and follow through with her discipline. She also taught Rosie about nutrition and helped her understand what had happened with Josh and her boyfriend. When CPS said that Rosie was not complying with her treatment plan, Cissy helped them realize that Rosie did not understand much of the therapist's language and could not keep up with the work. Cissy subsequently found Rosie an alternative therapist who specialized in individuals with developmental disabilities.

After nine months in placement, Cissy helped Rosie get AFDC assistance and obtain and furnish an independent apartment 8 blocks away from Cissy's house. Although Rosie was from another county, she did not want to go back there and had established a healthy support system in this new community. Cissy continued to serve as a general support to Rosie and helped her get involved in Josh's school. Rosie's CPS case was closed nine months after her SFC placement ended, and four years later, she is still living independently with her children and no further CPS reports.

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Becky, a 24 year old woman, has a long history of incest and was very isolated. She was raising her 5 month old son alone as his father, a 65 year old married "friend of the family," had no interest. Becky came to the attention of CPS when she took her son to the hospital and they discovered 31 fractures and extensive bruises. The infant was removed and placed in Cissy's care with the understanding that Cissy would help facilitate Becky's ongoing involvement with him. Becky picked her son up every morning and took him to an intensive therapeutic parenting program, returning him to Cissy at the end of the day.

Gradually, Becky began spending more time (half days and then weekends) interacting with her son at Cissy's house under Cissy's close supervision. Cissy helped Becky learn how to properly care for her son (e.g., how to pick him up, and feed and bathe him), and after a few months, Becky moved into Cissy's house. At first, the baby lived upstairs with Cissy, and Becky had her own room downstairs. After a few months, they moved the baby into Becky's room with a monitor and, after a few more months, removed the monitor. Cissy worked closely with the parenting program to teach Becky how to become more nurturing; she provided Becky with nurturing that she had never received and helped her heal her own wounds so that she could be more nurturing to her son. For example, when Becky began having flashbacks after moving into Cissy's home, Cissy found a therapist who specialized in incest and could help Becky address some of these issues.

After 14 months in placement, Cissy helped Becky find and furnish an independent, Section 8 apartment for her and her son. Cissy continues to work with Becky (meeting with her once a week) and provides respite care for Josh when needed. Becky continues to participate in the parenting program and incest survivors group to prevent isolation, and she recently started an accounting program which she attends while Josh is in subsidized day care. At this point, Becky's CPS case remains open, but no new abuse or neglect reports have been made.

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Sheila, a 35 year old woman, had a 15 year history of substance abuse which affected her ability to raise her school age child, Tanya. Sheila felt intense guilt about what she had exposed her young daughter to, including having sex in exchange for drugs while Tanya was in the next room. Sheila's mother took custody of Tanya, and when Sheila's mother refused to let her in, Sheila was homeless.

Sheila came to *A New Life Program* seven months pregnant, with her daughter, now 11, still in her mother's care. The fear of losing her newborn to foster care motivated Sheila to seek help prior to giving birth. Sheila was placed in a mentor home and she began to attend the day treatment program at the community center. Through the program, Sheila attended educational classes which taught her about her addiction and how to maintain abstinence, and she participated in individual and group therapy which enabled her to share feelings about herself. While she was in therapy and groups, her newborn attended the center's day care except during daily parent-child interaction groups where Sheila learned to interact positively with her baby.

To supplement these activities, Sheila's mentor, Hatty, worked with her in the evenings and weekends during her six-month placement. Sheila gave birth after the first month with Hatty who assisted her in learning how to care for a newborn. Hatty supported Sheila and helped her food shop, prepare nutritional meals, do her laundry, stick to a schedule and budget her money. These life skills were crucial to Sheila in her recovery, as she had a long history of being irresponsible with her money and leaving household tasks to her mother.

By the end of her mentor home placement, Sheila had learned well-baby care and life skills needed to move onto transitional housing. But more importantly, she had experienced positive parenting for herself from Hatty who both nurtured Sheila and held her responsible for her own chores and responsibilities. Sheila moved into *A New Life's* transitional housing where her older daughter, Tanya, was reunited with her, first on weekends and eventually full time. During her one year stay in transitional housing, Sheila participated in family counseling which helped her talk to her mother and Tanya in new ways. She was able to ask her mother for support without leaving her with all the parenting responsibilities, and she learned to address Tanya's behaviors appropriately. She also attended a vocational training program and then began community college. Meanwhile, her toddler continued to attend day care at the center, and Tanya attended the afterschool program.

Now Sheila and her two daughters live in independent permanent housing and they continue to attend the family support program at the center. As a result of her mentor placement and transitional housing, Sheila has many supports and continues to visit Hatty and share events with her.

For More Information About Shared Family Care

SEE...

Barth, R.P. (1994). Shared family care: Child protection and family preservation. *Social Work*, 39(5), 515-524.

Cornish, J. (1992). Fostering homeless children and their parents too: A unique approach to transitional housing for homeless families. *Community Alternatives: International Journal of Family Care*. 4(2), 44-59.

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Williams, L.M. & Banyard, V.L. (1995). *A New Life: An evaluation of a family reunification and child abuse prevention program for crack-addicted women and their children*. Philadelphia, PA: Crime Prevention Association of Pennsylvania.

CONTACT...

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Richard P. Barth, School of Social Welfare, University of California, 120 Haviland Hall, Berkeley, CA 94720. Ph (510/642-8535); Fax(510/643-6126);e-mail (rbarth@uclink2.berkeley.edu).

Jean Cornish, MN Human Service Associates, 570 Asbury St., Suite 105, St. Paul., MN 55104-1849. Ph (612/645-0688); Fax (612/645-9891).

Janet Keyser, A New Life Program, Crime Prevention Association, R.W. Brown Community Center, 1701 North 8th St., Philadelphia, PA 19122. Ph (215/763-0900); Fax (215/763-8088).

Linda Thorell, Adolescent Mothers Resource Homes Program, Children's Home & Aid Society of Illinois, 217 N. Jefferson Street, Chicago, IL 60661. Ph (312/831-8774).

*The *Shared Family Care Program Guidelines* are available for $15.00 from the AIA Resource Center. To purchase a copy, contact Amy Price at the number above.

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Shared Family Care: Child Protection Without Parent-Child Separation

by Amy Price, M.P.A. and Richard P. Barth, Ph.D.

Shared Family Care (SFC) refers to the *planned provision of out-of-home care to parent(s) and their children so that the parent and host caregivers (mentors) simultaneously share the care of the children and work toward independent in-home care by the parent(s).* SFC is a reparenting program in which adults learn parenting and living skills necessary to care for their children and maintain a household while dealing with their own personal issues and establishing positive connections with community resources. By simultaneously ensuring a child(ren)'s safety and preserving a family's ability to live together, SFC prevents unnecessary family separation and promotes permanency for children. This model can be used for prevention—making it unnecessary to separate a parent(s) from her or his child; for reunification—providing a safe environment in which to reunite a family that has been separated; or to help parents make the decision to terminate their parental rights and facilitate alternative permanency plans for the child.

Shared Family Care vs. Traditional Foster Care Arrangements

Few traditional foster care programs in the United States allow parents to reside with their children in placement. In shared family care (SFC), the entire family (i.e., at least one parent with at least one child) is placed together in another family's (the "host" or "mentor") home. Although the host family serves as an advocate, resource, and mentor in parenting and daily living skills, the biological parent(s) maintains primary responsibility for the care of her/his child. In regular foster care, children may learn a different way of life; in SFC, children and their parents learn to live together as a family.

Further, because SFC serves intact families in private homes, state licensure typically is not required, although mentor homes must meet certain criteria regarding space, sleeping areas, and health and safety regulations. Some programs may choose to license mentor homes to enable a child to remain in that home with the same care provider if the parent relinquishes her/his parental rights or is otherwise separated from the child. This alternative, however, may require a waiver from the state licensing agency to allow an adult related to the child to reside in the same home.

Cost and Funding of Shared Family Care

The monthly cost of SFC is generally higher than basic family foster care, comparable to treatment foster care, and probably less than institutional care or intensive family preservation (see chart below). However, because SFC placements typically are shorter than foster care, SFC appears to be, at a minimum, cost neutral. Factoring in the efficiency of placing more than one child in the same home with their parents, thereby eliminating the need for other shelter arrangements, SFC may result in fiscal savings if it achieves permanency for children at an earlier point.

State and Federal family preservation programs are the most viable source of funds for shared family care placements, case management, and mentor compensation. Title IV-E (Foster Care and Adoption) funds can finance the placement of *teen* parents and their children in mentor homes, and, through Federal waivers, these funds may be available for the placement of adult- headed families in certain states. TANF also should be available to support client families in shared family care and finance some of the support services. Other potential funding sources include state and local child welfare, substance abuse and homeless programs. Private resources can support planning, start-up, and evaluation, and help fill in other funding gaps (e.g., respite, training, and aftercare).

Existing Programs

A few programs in the U.S. have been using this model of shared family care for several years. *A New Life* Program, at Crime Prevention Associates in Philadelphia, Pennsylvania, uses SFC as part of an intensive drug treatment program for women with infants. Minnesota Human Service Associates, a treatment foster care agency in St. Paul, provides SFC to a wide variety of families through their *Whole Family Placement Program*. Children's Home and Aid Society of Illinois' *Adolescent Mothers Resource Homes Project*, and The Children's Home Society of New Jersey's *Extended Family Care Program*, use this model to place teen parents with their children.

Anecdotal evidence suggests that these programs are effective at keeping families together and promoting permanency for children. In the first two years of implementation, for instance, 23 of 46 (50%) families in Minnesota HSA's *Whole*

Category of Care	Average Monthly Maintenance Cost	Median Service Duration	Average Total Maintenance Cost
Conventional Supervision	$233	6 months	$1,400
Intensive Family Preservation	$2,800	1.5 months	$4,200
Basic Family Foster Care	$362	14 months	$5,068
Shared Family Care	$1,575	5 months	$7,875
Treatment Foster Care	$933	14 months	$13,062
Transitional Housing Program	$3,000	6 months	$18,000
Residential Drug Treatment	$3,242	6 months	$19,452
Institutional Care	$3,600	13 months	$46,800

*** The above data is based on National averages with the following exceptions: The median service duration for basic family, treatment, and institutional foster care are based on California statewide averages, and the data for Shared Family Care is based on an average of two programs: *Whole Family Placement* in St. Paul, MN, and *A New Life Program* in Philadelphia, PA.**

Family Placement Program moved as a family to independent housing with no Child Protective Service (CPS) involvement. Eight of the parents (17%) left their children in foster care, and 5 of those children were subsequently adopted. The remaining families were still in placement at the time of the report. Of the 23 families who moved onto independent living, none of them had subsequent involvement with CPS within six months after placement termination. In contrast, approximately 12% of children who are reunified with their families after a regular non-kin foster care placement in California re-enter care within six months (Needell, Webster, Barth, & Armijo, 1995).

Current Efforts

In 1996, the National Abandoned Infants Assistant (AIA) Resource Center, at the School of Social Welfare, University of California at Berkeley, published *Shared Family Care Program Guidelines* to disseminate information about SFC and provide guidance to agencies interested in using this model for families involved, or at risk of involvement, in the child welfare system. With support from the Zellerbach Family Fund, the AIA Resource Center has helped to establish two demonstration projects in California and is consulting with five in Colorado. All these programs (which are at various stages of development) are being administered through county child welfare agencies (several through contract with community based organizations), and all are participating in an evaluation being conducted by the AIA Resource Center. The evaluation will follow participating families throughout their placement (approximately 6 - 9 months) and for one year after placement. In addition to program documentation and evaluation instruments, the Resource Center also has developed a *Curriculum Outline and Resource Guide for Shared Family Care Mentor Training*. These materials, along with the *Program Guidelines*, are available from the AIA Resource Center.

Conclusion

Although shared family care is a relatively new concept for child welfare services in the United States, it reflects age-old practices in the African-American community, and is widely used in several Western European countries. There is reason to believe that this model can help reduce the trauma caused by separating children from their families and shuffling children between homes for prolonged periods of time. We also believe that the IV-E waivers and the proposed federal legislation to reimburse time-limited placements of families will encourage the expansion of this approach in the 21st century.

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Needell, B., Webster, D., Barth, R.P. & Armijo, M. (1995). *Performance indicators for child welfare services in California: 1995*. Berkeley: Child Welfare Research Center, School of Social Welfare, University of California.

For more information or to request materials, contact: ***Amy Price****, National AIA Resource Center, 1950 Addison St., Suite 104, Berkeley, CA 94704-1182. Ph (510/643-8383); Fax (510/643-7019); e-mail (amyprice@uclink2.berkeley.edu); or* ***Richard P. Barth****, School of Social Welfare, University of California, 120 Haviland Hall, Berkeley, CA 94720. Ph (510/642-8535); Fax (510/643-6126); e-mail (rbarth@uclink2.berkeley.edu)*

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Resource Guide

(Foster Care, Kinship Care, Subsidized Guardianship, Shared Family Care, etc.)

American Association of Retired Persons (AARP) Grandparent Information Center
(Parenting Grandchildren)
601 E Street, N.W.
Washington, DC 20049
202-434-2296
http://www.aarp.org

American Humane Association
(Subsidized Guardianship/Strengths-Based Family Assessment)
Children's Division
63 Inverness Drive East
Englewood, CO 80112-5117
303-792-9900
http://www.amerhumane.org

American Public Welfare Association
(Foster Care/Kinship Care)
810 First Street, N.E., Suite 500
Washington, DC 20002-4267
202-682-0100
http://www.apwa.org

Child Welfare League of America, Inc.
(Foster Care/Kinship Care)
440 First Street, N.W., Suite 310
Washington, DC 20001
202-638-2952
http://www.cwla.org

Families for Kids
(Foster Care/Adoption)
W.K. Kellogg Foundation
P.O. Box 550
Battle Creek, MI 49016-0550
http://www.wkkf.org

National Abandoned Infants Resource Center
(Shared Family Care)
1950 Addison Street. Suite 104
Berkeley, CA 94704-1182
510-643-8383
http://www.hav54.socwel.berkeley/cssr/airc/tech/sfc.htm

National Resource Center for Permanency Planning (Permanency Options)
Hunter College School of Social Work
129 East 79th Street
New York, NY 10021
212-452-7029
http://hunter.cuny.edu/socwork/nrcppab.htm

National Foster Care Resource Center
(Foster Care)
Eastern Michigan University
King Hall
Ypsilanti, MI 48197
313-487-0372

National Indian Child Welfare Association
(Foster Care/American Indian Children)
3611 SW Hood Street, Suite 201
Portland, OR 97201
503-222-4044
http://www.nicwa.org

National Network for Family Resiliency
(a site of the U.S. Department of Agriculture's Cooperative
Extension Service and CYFERnet)
http://www.agnr.umd.edu/users/nnfr

Relatives as Parents Program (RAPP)
The Brookline Foundation Group
126 East 56th Street
New York, NY 10022-3668

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Shared Family Care Evaluation Plan

Overview

Shared Family Care (SFC) is an innovative model for serving parents and children together (see attached fact sheet). As an alternative to traditional family preservation services or out-of-home care, SFC promotes the safety of children while preventing the unnecessary and traumatic separation of parents and children. Its long-term intended effects are:

- safety of children in participating families;
- greater stabilization and self-sufficiency among participating families; and
- improved well-being of children and parents who participate in the program.

The model is based on the following principles:

- Every child deserves a safe, healthy, nurturing environment in which to grow.
- Most children are better off in a family setting.
- Families should remain together if at all possible.
- In order to support a child, it is necessary to support the child's parent(s).
- Parents' basic needs (e.g., food and housing) must be met in order for them to effectively address psychosocial, emotional or parenting issues.
- Families learn best from each other.
- Families should be placed in homes in which they are culturally comfortable, and in communities in which they can feasibly transition to independent living.
- Compatibility between mentor and participant families is important and is achieved through comprehensive, individualized assessment and careful matching.
- Relevant and accessible services and support may be needed to help families move toward independent living in the community.

SFC also is based on:

- the belief that, in some cases where in-home services (e.g., intensive family preservation) may not be enough to adequately protect a child, 24 hour support and supervision from a mentor may be effective in preventing unnecessary separation, and
- the knowledge that inadequate housing or homelessness frequently is a primary factor leading to foster care placement or preventing reunification.

Based upon these premises, Shared Family Care refers to **a situation in which an entire family is temporarily placed in the home of a host family who is trained to mentor and support the biological parent(s) as they develop skills and supports necessary to care for their child(ren) and move toward independent living.**

Key elements of this model include:

- Mentor families from the community who are carefully screened and who receive extensive training in child safety and child welfare issues; child development; parenting; adult communication and conflict resolution; community resources; and other issues related to family preservation.

- Participating parents who demonstrate a desire to care for their children and a readiness to work on an individualized service plan, and who are homeless or marginally housed.
- Careful matching between mentor and participant families, a rights and responsibilities agreement between both families, and an individualized service plan developed jointly by the participant and mentor families, a case manager, a child welfare worker, and any one else involved with the participant family.
- Services which include: teaching and mentoring parenting and living skills necessary for adults to become adequate parents and maintain a household; clinical treatment and counseling to help parents address their own personal issues; and helping parents establish positive connections with community resources that are necessary for them to become self-sufficient.

Anticipated Outcomes

The two SFC programs that have been successfully implemented in the United States were developed through private non-profit organizations (a state-wide treatment foster care agency and a community center). To determine whether this model can effectively achieve its intended effects if administered through a public agency, and ultimately become a standard service in the public continuum of care, Zellerbach Family Fund awarded a planning grant to Alameda and Contra Costa County Social Service Departments to develop demonstration Shared Family Care projects, and to the National Abandoned Infants Assistance Resource Center, at University of California at Berkeley, to evaluate the projects. The purposes of the evaluation are: (1) to provide information to interested parties about the effectiveness of shared family care (SFC) as an alternative to currently available services for keeping families together and developing safe, permanent plans for children; (2) to provide information--for expansion, replication or improvement--on what works and what does not work in the implementation of SFC; (3) to demonstrate comparative costs of the program; and (4) to understand who can benefit from SFC and who is likely to participate as a mentor/host family. The evaluation plan has been designed to assess the following early, intermediate and long-term anticipated outcomes of shared family care.

<u>Early Outcomes</u>

Early outcomes reflect the process of establishing SFC projects through public child welfare agencies. Specific goals include:

- Develop an overall program plan that identifies the target population and what services will be provided by whom, and that determines licensing issues, time frames, and general procedures.
- Develop a budget and identify ongoing funding sources for operating expenses.
- Establish a contract (or some other form of agreement) with an implementing agency.
- Recruit, train and certify (or license) mentor families.
- Educate referral sources (e.g., county child welfare workers) about the program.
- Develop program tracking forms.

Intermediate Outcomes

Once the programs are developed, the implementation process will be assessed against the following intermediate outcomes:

- Child welfare workers will refer appropriate participant families to the SFC project.
- Participant families will be matched with mentor families, and both parties will sign the Rights and Responsibilities Agreement.
- Each participant family will work with their mentor, case manager, child welfare worker, and other service providers (e.g., AOD counselor, probation officer) to develop an Individualized Family Plan (IFP) which identifies the family's strengths, needs, goals, and activities to achieve those goals.
- Services will be provided (directly and through linkage with community resources) to families to address needs identified in their IFP, e.g., learning to make good decisions and to meet their children's needs, meeting their parental responsibilities, maintaining recovery, becoming self-sufficient, etc.
- Children whose parents choose to or are forced to relinquish their parental rights while in placement will receive continuity of care and permanency planning services.
- Mentor families will receive ongoing training and respite.

Long-Term Outcomes

It is anticipated that SFC will result in the following long-term outcomes for participant families who complete a placement:

- Greater independence and stability in the community.
- Improved parent-child interaction and overall family functioning.
- No subsequent child abuse and neglect reports.
- Improved emotional and physical well-being of child and parent participants.
- Mentor families will feel better about themselves as individuals and as members of the community, and feel more knowledgeable about working with families in need.

Additionally, SFC is expected to be, at a minimum, cost neutral in the long run.

Early outcomes will be measured through notes from various planning meetings, reports and conversations with the program coordinator, contracts, and quarterly reports indicating the number of mentors recruited and trained. **Intermediate outcomes** will be documented through participant Intake Forms, Rights and Responsibilities Agreements, Individualized Family (Case) Plans, Monthly Services Reports, Mentor Daily Logs, Mentor Applications, Quarterly Reports (indicating training and respite provided to mentors), and participant case records. **Long-Term Outcomes** will be measured both quantitatively and qualitatively based on the following indicators of change.

OUTCOMES AND INDICATORS OF CHANGE IN THE EVALUATION OF SHARED FAMILY CARE

Theories of Change	Outcomes	Source of Information	Indicators
By simultaneously protecting children and preserving families, Shared Family Care fills a critical service gap between traditional family preservation and out-of-home care.	• Can SFC be incorporated into the standard continuum of county child welfare services? • Is there public money available to fund a SFC project? • Are there families in the community interested and qualified to be mentors? • Will participants be referred to the project?	• Notes from planning meetings and project coordinator. • Project plans and budgets. • Quarterly reports. • Intake forms	• What was the time between receipt of the grant and placement of first family; how many meetings were held; and who was involved in what activities? • Who will provide the services and through what kind of agreement? • How much will the projects cost and what sources will be used to finance them? • How many mentors are recruited, oriented, certified and trained? • How many families are referred to the project?
Mentors who receive training, support and supervision, and who are carefully matched with participant families, play a critical and unique role in helping families meet their goals.	• Are participant and mentor families being matched appropriately? • Are mentors receiving sufficient training and support to do their job? • Are participant families receiving necessary services from the mentor and the community? • What families are most likely to succeed as mentors? • Are families progressing toward their goals?	• Individualized Family Plans (IFPs) & progress notes • Quarterly reports • Participant Intake Forms • Mentor questionnaire • Monthly Service Report • Participant questionnaire • Mentor Applications • Mentor Daily Log	• How many hours of training, support and respite are provided for how many mentors? • How satisfied are participants and mentors with their placement? • What services are mentors providing to participants? • To what extent are families progressing toward their goals? • What are characteristics of participant and mentor families? • Do participant families have multiple SFC placements?

Theories of Change	Outcomes	Source of Information	Indicators
Families are more likely to become stable and self-sufficient if their basic needs (e.g., housing) are met and a mentor helps them establish a positive network of community resources and supports.	• Upon completing a placement, are participant families able to obtain the resources and supports they need to maintain stability and live independently in the community?	• Participant questionnaire • Participant interview • Social worker notes and team meeting reports	• Do participants who complete a placement move into and maintain stable housing in the community? • To what extent do participants who complete a placement feel that they have sufficient social supports? • Are families more involved in the community after their placement?
Most individuals care for their children the way they were cared for, and many parents in the child welfare system did not receive appropriate or adequate parenting themselves. By nurturing and reparenting these adults, and modeling and teaching them appropriate parenting and home management skills, SFC helps parents better protect and care for their children and helps families interact in healthier manner.	• Are children in participating families safer and better cared for after their families complete a SFC placement?	• Monthly progress report (completed by mentor and participant) • Automated child welfare system • Participant interview • Social worker notes and team meeting reports	• Do participant families avoid subsequent reports of abuse or neglect at least up to one year after completing their SFC placement? • Do SFC participants maintain custody of their children at least up to one year after completing their SFC placement? • Are parents caring for and interacting with their children more appropriately than before their placement?
By keeping families together, SFC minimizes the emotional trauma to children and parents caused by separation. Also, by providing a secure home and helping families meet their basic needs, SFC improves the physical and mental well-being of children and their parents.	• Do participating parents and children have improved emotional and physical health after completing a SFC placement?	• Participant questionnaire • Participant interview • Social worker notes and team meeting reports • Monthly Progress Report	• Are children behaving appropriately in school/day care and at home? • Are parents caring for themselves and their children?

Theories of Change	Outcomes	Source of Information	Indicators
Community members who mentor participant families have an opportunity to contribute to their community and acquire new skills, thereby improving their self-perception.	• Do mentors feel better about themselves as individuals and as members of their community as a result of their involvement in SFC?	• Mentor questionnaire	• Do mentors indicate improved feelings of self-worth? • Do mentors continue to participate in the SFC program after their 1st placement?
If, after a 6-9 month placement, SFC is successful at keeping families together and preventing subsequent out-of-home placements, the long-term cost of the program will be significantly less than traditional foster care options (which often are longer than 9 months and, in as many as 25% of the cases, result in subsequent placements).	• Is Shared Family Care more cost effective than more traditional out-of-home options?	• Participant Intake forms • 12 month participant interviews • automated child welfare system • program cost data	• How long are families in placement? • How many SFC graduates have subsequent involvement with the child welfare system?

Funding Resources for Shared Family Care

RESOURCE	POTENTIAL USES
Private Resources	
• Charitable foundations • Religious organizations • Community organizations (e.g. Lions Club, sororities) • Local businesses	• start-up costs (don't underestimate this expense) • housing allowance for mentor (e.g., for furniture or minor changes to bring their house up to code) • respite for mentors • client's transition after placement (e.g., security deposit) • evaluation
Local & State Agencies	
• Alcohol and drug treatment agencies (e.g., federal Substance Abuse Prevention & Treatment Block Grant is a passed through the states based on a formula.)	• parent's portion of the placement • case management services • treatment, recovery support and relapse prevention
• State or local child welfare funds (e.g., through general fund or state family preservation program)	• child's portion of the placement, case management, and any thing else allowed under the state or local plan.
• Local Public Housing Authority	• provide Section 8 vouchers to participant families completing a placement • make larger public housing units available to residents who want to become mentors
• State or local homeless prevention programs (e.g., housing trust funds)	• assist families transitioning out of placement (e.g., by providing security deposits, first month's rent, etc.)
Federal Programs	
• Title IV-B (Family Preservation)	• any part of shared family care (e.g., maintenance allotment, respite, case management). These funds are passed through state and/or local agencies.
• Title IV-E (Foster Care)	• placement of and services to financially eligible teen parents and their children • training of and administrative support (e.g., supervision, recruitment and licensing) to mentors if they are licensed care providers • training of public agency staff • child's portion of the placement <u>if</u> child is in legal custody of the state <u>and</u> the mentor is a licensed care provider <u>and</u> your state allows it (MN HSA uses it this way) • potentially placement of any financially eligible family in states with a IV-E waiver or with passage of federal legislation

TANF	• eligible families should continue to receive TANF while in placement if they are expected to provide for their own (and their children's) basic necessities. • a portion of the family's allotment can be paid to the mentor as rent and considered part of the mentor's compensation
Title XX (Social Services Block Grant)	• any service included in state's plan (although in most states, these funds are already allocated elsewhere)
Food Stamps	• eligible families (participant and mentor) can receive food stamps in placement as long as they are each expected to purchase and prepare their food separately (note: if the mentor and participant family purchase food together, their two incomes can be combined to determine household eligibility for food stamps)
SSI	• eligible family members should continue to receive SSI benefits while in placement • like TANF, a portion of a family member's SSI benefits can be paid to the mentor as rent and considered part of the mentor's compensation
Medicaid	• depending on state, may cover targeted case management for children in placement, and rehabilitative services (e.g., therapy), transportation to services, and respite care for certain populations (e.g., HIV, medically fragile) who would otherwise be institutionalized
Housing Rehabilitation Program	• provides financial and technical assistance to low-income home owners to rehabilitate their homes, and emergency grants to correct conditions that are a health or safety danger (e.g., may be used to help mentors bring their houses up to code)
Emergency Shelter Grants Program (part of McKinny SuperNova developed by state and local collaboratives)	• can be used for placement if local plan considers SFC emergency or transitional housing
HOPWA (Housing Opportunities for Persons with AIDS)	• support services, rental assistance, etc. for families affected by HIV/AIDS (passed through state and local agencies)